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Understanding African American Men's Perceptions of Racism, Male Gender Socialization, and Social Capital Through Photovoice

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Abstract

In this study we used a participatory qualitative research approach—photovoice—to collect information about African American men's perceptions of the factors that influenced their own health and the health of their communities. Photovoice was conducted as part of the “Men as Navigators (MAN) for Health” project, an evaluation of a male lay health advisor (LHA) intervention in central North Carolina. Twelve African American men living in both urban and rural communities took photographs and discussed the photos in six photo discussion sessions. Analysis involved identifying recurring themes from the photos and transcriptions of photo discussions. The results suggest that race and racism, male gender socialization, and social networks and social capital all have important influences on African American men's health. The implications for further research and public health practice are discussed.

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Keywords

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The health of men is a growing but understudied public health concern. According to age-adjusted mortality rates for the leading causes of death in the United States, men have higher death rates than women for 14 out of the 15 leading causes of death (Williams, 2003). Among men, the most neglected populations—who experience the poorest health outcomes and confront the largest barriers to health care—are men of color (Satcher, 2003). These disparities are significantly pronounced among African American men. For example, the life expectancy for African American men is more than 7 years shorter than that of White men (National Center for Health Statistics, 2007). African American men die of heart disease at a rate of 342.1 per 100,000, whereas the rate among White men is 264.6 per 100,000. Cerebrovascular disease is twice as likely to kill African American men as it is to kill White men or women (National Center for Health Statistics, 2007). With regard to cancer, the 2004 death rate among African American men was 301.2 per 100,000 in comparison to a death rate of 224.4 among White men (National Center for Health Statistics, 2007). Moreover, African American men are less likely than White or Latino men to see a doctor when they are in poor health, are less likely to receive preventive services, and are more likely to receive delayed medical attention regardless of insurance status (Brown, Ojeda, Wyn, & Levan, 2000; Gornick, 2000; Smedley, Stith, & Nelson, 2003; Williams, 2003).

The empirical and theoretical literature suggests that social injustice and adverse social determinants of health are the root causes of poor health outcomes among racial and ethnic minorities (Krieger, 2005; Link & Phelan, 1995). Social determinants are factors at the societal and community levels that influence health directly and through more proximal determinants (Schulz & Northridge, 2004). Key determinants that have been found to influence health include socioeconomic status (SES), racism, gender, the physical environment, residential racial segregation, and geography (Krieger, 2005; Marmot, 2005; Marmot, Rose, Shipley, & Hamilton, 1978; Williams & Collins, 2001). According to Schulz and Northridge's conceptual model of social determinants, factors at the societal and community levels influence health through more proximal determinants (Schulz & Northridge, 2004). For example, larger social factors and existing inequalities in society contribute to an imbalance of resources and opportunity in the physical, economic, and social environments of a community. These latter factors, in turn, influence the stressors, health behaviors, and social resources of individuals, which are reflected in their health status and overall well-being.

Although several studies have demonstrated the independent effects and intersection of multiple social determinants on the health and well-being of African American men (Hammond, Banks, & Mattis, 2006; Williams, 1999; Williams & Collins, 2001), only a few qualitative studies have documented African American men's perceptions of health and health influences (Griffith et al., 2007; Plowden & Miller, 2000; Plowden & Young, 2003; Ravenell, Johnson, & Whitaker, 2006; Royster, Richmond, Margolis, & Eng, 2006). Furthermore, most of these studies have focused on the factors contributing to African American health behaviors and health care seeking (Plowden & Miller, 2000; Plowden & Young, 2003; Ravenell et al., 2006). Those that have assessed African American men's attitudes about social determinants of health have found that male gender socialization, racism, and socioeconomic status contribute to their health. Assessing individuals' perceptions is important to understanding how aware they are of the factors influencing their health, and thus their ability to take action to address these issues. Individual or community understanding of social determinants of health is the first step toward community action.

In this study, we used photovoice to collect information about African American men's understanding of the factors that influence health. Photovoice is a qualitative, community-based, participatory research approach that involves providing cameras to community members so that they might visually represent and communicate their lived experiences to others (Lopez, Eng, Robinson, & Wang, 2005; Oliffe & Bottorff, 2007; Wang & Burris, 1997). The goals of photovoice are (a) for participants to record and reflect their community's strengths and concerns, (b) to promote critical dialogue and knowledge about important community issues through group discussions and photographs, and (c) provide a forum for the presentation of people's lived experiences through their own images and language (Carlson, Engebretson, & Chamberlain, 2006; Wang, 1999; Wang & Burris, 1997). Photovoice also serves as a mechanism for connecting communities to policymakers. Through this process, we hoped to learn more about the social determinants of health for African American men in central North Carolina.

Methods

Photovoice was conducted as part of the "Men as Navigators (MAN) for Health" project, an evaluation of a male lay health advisor (LHA) intervention in central North Carolina. The goal of the "MAN for Health" study was to use a community-based participatory research (CBPR) approach to improve health behaviors among urban and rural African American men by focusing on social factors that contribute to gender and racial health disparities. The intervention took place in two counties, one rural and one urban, between November 2005 and September 2006. In the rural county, the intervention aimed to improve prostate health behaviors among African American men. In the urban county, the focus was on cardiovascular health behaviors among African American men. The lay health advisors aimed to improve the health of men in their social network by encouraging them to take greater control of their preventive health and help-seeking behaviors. They also served as coinvestigators throughout the study. Photovoice was conducted in both the urban and rural project sites as part of the process evaluation, to gain information on men's knowledge of the health issues present in their communities and their work as lay health advisors. Human subjects approval for the study was obtained from the University of North Carolina Public Health Institutional Review Board (IRB) prior to data collection.

Setting and Participants

Photovoice was conducted in both the urban and rural project sites between November 2005 and September 2006. The rural county covers 400 square miles and is classified as 60% rural. According to the 2006 American Community Survey, an estimated 120,100 people lived in the county (U.S. Census Bureau, 2006). African American residents make up 12.5% of the population, with males accounting for 47.8% of the population. The urban county covers over 860 square miles and is largely urban and suburban. As of 2006, an estimated 786,000 residents lived in the county (U.S. Census Bureau, 2006), with males accounting for 49.6% of the population and African Americans comprising 20% of the residents.

A total of 33 lay health advisors, called navigators, were recruited and trained in the urban ($n = 20$) and rural ($n = 13$) project sites. The navigator training included a description of the photovoice methodology being used for the process evaluation. Once the intervention began, the principal investigator and a graduate research assistant attended regular navigator meetings to recruit navigators to participate in the photovoice component of the project. In the rural county, five navigators participated in the photovoice project, with an average of four men attending each photo discussion session. In the urban county, a total of seven navigators participated in photovoice with an average of five men per photo discussion session. The ages of the men ranged from 18 to 62 with a mean of 45 years. Most had lived in their communities

for more than 25 years. The majority of the men were employed (80%) and had an annual income of more than \$40,000 (60%). The men at the urban site were more likely to be married (86% vs. 40%, respectively), and had higher levels of education than those at the rural site (72% vs. 20%, respectively, held a bachelor's degree).

Procedures

The photovoice process began with informational meetings at each site. The purpose of the first meeting was to explain photovoice, build rapport between the participants and investigators, and obtain informed consent from the participants. Each participant was given two copies of the project fact sheet and consent form, one copy to sign and return, and one copy to keep for future reference. This was to ensure that each participant understood the purpose of the project, what it entailed, and that he could terminate involvement at any time he wished. At this session, the participants had an opportunity to ask questions about the process and were also given brief instructions on how to operate a disposable camera. Participants discussed the ethical issues involved in taking photographs and were trained to get permission and informed consent from any subjects that could be identified in the photographs.

At this meeting, navigators engaged in a brainstorming exercise to develop a list of photograph (photo) assignments for future sessions, all of which related to their role as lay health advisors and the health of their communities (see Table 1). The group selected one assignment from the list to complete and scheduled a time when they could all come together for the first photo discussion session. Each of the men was given a disposable camera to take photos that represented the chosen photo assignment.

After the initial information session, photo assignments and discussion meetings were completed at each site approximately once each month, for a total of six assignments/meetings at each site. Participants were given a new disposable camera for each photo assignment. After completing each photo assignment, navigators returned their cameras to the project coordinator at each site, who had the photographs developed at no cost to the participants. Prints of the photos were returned to the participants in sealed envelopes at the photo discussion meetings.

During the photo discussion sessions, navigators selected the photos they wanted to share with the group and provided an explanation regarding how selected photos related to the photo assignment. The group then chose one or two photographs from all the photos to serve as the focus for the discussion. The discussions were facilitated by either the principal investigator or a graduate research assistant, using a Freirean-based critical dialogue technique (SHOWED) to help men identify, reflect, and act on health-related issues in their own communities (Wallerstein & Bernstein, 1988; see also Freire, 1970, 1973).

SHOWED is a series of questions used to guide discussion from a personal level to social analysis and action steps (Wallerstein & Bernstein, 1988). The questions include (a) What do you see in this photograph? (b) What is happening in this photograph? (c) How does this relate to our lives? (d) Why do these issues exist? (e) How can we become empowered by our new social understanding? and (f) What can we do to address these issues? At the conclusion of each session, navigators agreed on the next photo assignment and schedule (date, time, and location) for the next photo discussion. Each photo discussion took approximately 1.5 hours to complete.

Data Analysis and Interpretation

Photo discussions were audio recorded and notes were taken at each session. Recordings were transcribed verbatim for content analysis. All transcripts and notes were initially read by the principal investigator and the graduate research assistant who conducted the photo discussions.

A coding scheme was developed based on the interview guide and the transcripts themselves. Similar codes were grouped into broader concepts to facilitate the analysis. Each transcript was coded using the coding scheme by at least two members of the research team. The research team included the principal investigator, a postdoctoral research fellow, two graduate research assistants, and two project coordinators from a partner community agency. Coded transcripts were entered into a software program for qualitative data analysis (Atlas.ti, 2003) and team members reviewed quotations for each of the broader concepts. Analysis involved identifying recurring themes and comparing and contrasting the experiences of navigators at each site. The initial analysis of the photo discussion was presented at community forums, which allowed the men the opportunity to review and comment on the findings. Photographs and themes that emerged in both the rural and urban counties are presented below.

Results

Our analysis of the photos, photo assignments, and photo discussions revealed that the men who served as lay health advisors in “MAN for Health” had a rich understanding of social determinants that influence the health of African American men in their communities. Although the men were health conscious, they struggled with societal conditions to stay in good health. We identified several themes from the data related to social determinants of health and organized them into three categories: race and racism, roles and responsibilities of being an African American man, and social networks and social capital. We present these themes and our analysis of the data below; however, we use the words of the men whenever possible to illustrate their meaning and context. Although we consistently used the term African American to describe the racial identity of the men participating in the study, they often chose to use the term Black to describe themselves and their communities in the photo discussions. Thus, to accurately reflect their language we use the term Black in their quotations and the list of photo assignments.

Race and Racism

Our analysis revealed the following themes related to race and racism:

- The physical and social environments African American men live in often lack the conditions and resources for the men to be in good health.
- Many community institutions serving African Americans, such as hospitals and businesses, have been abandoned or neglected by mainstream society, and thus, the physical environment serves as a constant reminder of institutional racism.
- Interpersonal racism is a daily stressor of being made conscious of living as an African American man.
- Products such as alcohol and unhealthy foods are often specifically marketed by commercial industries to African American men.

The photo discussions revealed that the men were extremely conscious of their status as a racial minority. The men spoke openly about experiencing forms of both institutional and interpersonal racism and how they impacted their communities. According to the men, institutional racism was present in the conditions of the segregated neighborhoods in which they lived, and was documented in both their photographs and their discussions. Thus, living in racially segregated neighborhood environments decreased the availability of resources to maintain their health, increased their exposure to unhealthy products, and served as a chronic stressor.

Many were aware of the history of segregation in their neighborhoods and photographed locations in their communities that had been previously segregated. For example, one man took

a picture of a cemetery where previously only White people had been allowed to be buried. Another took a photograph of a historically African American hospital that had since been abandoned (see Figure 1). The photographs elicited discussion of other community institutions serving African Americans that had been abandoned or neglected by mainstream society. One man described what had happened to the abandoned hospital:

In other words, there was no one fighting for the site [St. Agnes Hospital]. There was not enough information furnished for the site. There wasn't no one with a background to present it as a landmark, its qualifications and all of the things that it represented. ... But now with the information, I mean first we've just seen the picture. But then when we get together and boil all that information down, we've seen that that is a significant piece of a Black landmark, something that should be preserved and something that's worth fighting for.

Another man spoke about the lack of investment in historically African American neighborhoods:

Why don't you take your car and drive down the street a piece? Oakwood. Old houses over there. You know what they decided to do? They tore them down. ... Right there going by Saint Aug [Saint Augustine's College], you know what they're doing with it? They're pushing them over, baby. Ain't no historical value in that 'cause Black people live in those houses. They pushed them over.

Thus, the men's physical environment served as a chronic stressor, because it served as a constant reminder of institutional racism in their communities.

The men described interpersonal racism as a daily stressor resulting from their increased consciousness of living as an African American man. One example they cited was the fear of being pulled over by police for "driving while Black." Other men shared experiences of specific racist encounters. As an illustration, one of the men described his experience of being discriminated against while seeking health care at a local clinic. A White receptionist at the clinic questioned his method of payment while he was checking in for an appointment, assuming that he would not be able to pay or did not have insurance. The man attributed the prejudicial treatment to the fact that he was African American.

The photo discussions revealed that the men had a clear understanding of how institutional and interpersonal forms of racism influenced the health behaviors and health status of African American men. For example, they noted how negative experiences of seeking health care might prevent African American men from returning for preventive or routine care. They also recognized that their physical and social environment often lacked the resources African American men need to stay healthy. For example, the men noted that due to institutional racism many African American neighborhoods have inadequate access to health care, places to exercise, and healthy foods.

As noted previously, unhealthy products were often specifically marketed to African American men. In the urban county, one of the photographs chosen for discussion was of a liquor section in a local grocery store (see Figure 2). This photograph elicited discussion about the causes and consequences of widespread alcohol use in the African American community. The men described how members of their community use alcohol to relieve stress, and cope with difficult situations in their lives, such as racism. However, many felt that the larger society perpetuated alcohol use in African American communities by marketing liquor products to African Americans and providing easy access to cheap liquor in African American neighborhoods. As one of the men stated,

You know, I think a lot of it is marketing certain foods to minority communities just like with alcohol. You know, you have all these alcohol spots in, you know, minority

communities and it's not necessarily that minorities drink more. But for whatever the reason that has been defined by, let's say, the power structure. You know, they have found a need to market certain products to certain people.

The consequence of increased alcohol use in African American communities is that it limits some men's opportunities. As one stated, "I love beer, but these guys have it every day all day long." Others noted that high rates of incarceration among African American men were often because of drug and alcohol offenses.

In the rural county, a similar discussion about the marketing of unhealthy foods took place because of a photograph of the meat section in a local grocery store. Although the men recognized cultural traditions of eating high-fat-content cuts of pork and processed meats, they also felt these traditions were perpetuated by the food industry, which marketed the foods to African Americans.

The discussions in both counties led to a similar conclusion: that promoting healthy behaviors among African American men might not be enough to improve their health. Larger social factors play an important role in determining men's health status. This did not stop the men from identifying opportunities for social action. Some men recognized their power as consumers to stop the pattern of marketing unhealthy products to African Americans. As one man stated,

Let's say, pork for instance. If we know ... that it's affecting our community, then we need to begin to communicate and talk more about the product that's contributing to, say for instance, hypertension and why we should alter our diet. And if we stop buying it, then they're going to stop wasting money putting it in the community.

Others suggested that future health education efforts focus more on the realities of dealing with racism, as opposed to promoting regular medical visits or healthy eating behaviors. As one man stated,

And we can try everything, you know ... healthy food ... trying to get the Black men to go to the doctor. But the fact is, what we need to do is get them to understand ... the system. They're not even taught how to deal with society, how to deal with the system.

Roles and Responsibilities of Being an African American Man

Another aspect of the men's identities that influenced their health was their gender. We identified the following themes related to gender socialization among African American men:

- African American men do not prioritize their own health because of the expectation that they are strong and healthy.
- Even among African American men who do give priority to their own health, the multiple demands placed on them make it difficult to find time to eat healthfully, exercise, and get regular health care.
- An important aspect of being an African American man is to take responsibility for their own lives, their family, and the conditions in their community.

The men discussed how norms and expectations of manhood influenced the attitudes and behaviors of African American men in their communities. In these men's communities, being sick or even seeking preventive health care is often seen as a sign of weakness that is not congruent with their image of masculinity. Many of the men held more than one job and were active in church and community groups, which left little time for self-care:

We're men, that's all. We're tough. So, the little aches and pains that we feel, we sleep on them and we wake up in the morning and we go on. Inside, our internal health is not important as long as outside we're physically able to still move. ... We don't have time to stop for other things, interruptions like going to the doctor.

Despite these competing demands, many of the men felt that an important aspect of being an African American man was to take responsibility over their own lives. Although this theme was reiterated throughout several photo discussions, two photo assignments in the urban site specifically focused on this topic: "why Black men are reactive instead of proactive," and "irresponsible Black men." During these discussions, the men expressed their frustration about why some men in their communities made excuses for not taking better care of themselves and their families. One of the men took a photo of an abandoned car, which he stated was a metaphor for "irresponsible Black men." Although he recognized irresponsibility as universal and existing across gender and culture, he described the photo and situation in his community this way:

Irresponsibility is a problem in our community. We see men who ignore, abandon, or make excuses for not following through with individual and family responsibilities even after community members and family members have tried to help. It's like an abandoned car, something valuable with so much potential being wasted.

Part of taking responsibility also meant working to improve the conditions in their communities. The men spoke about how it was important for African American men to share the burden of this responsibility with mainstream society. They understood that the neglect and deterioration in some African American communities was a result of institutional racism, but that African American men also had a role to play in demanding that the conditions improve. This sentiment was exemplified in the following comments.

You know, and like I said, I don't want to blame nobody for my problems. I know if somebody is actually creating a problem, that will be myself, you know? But the thing is, is that if we Black men do not know how to identify the problem, they're not going to know how to correct the problem.

This theme arose during the discussion of the photograph of the abandoned dilapidated building that had once been the only hospital that served African Americans in the state (see Figure 1). In discussing the photo, some men believed that it was the responsibility of both the local African American residents and White residents in other parts of the city to enhance the physical environment of African American communities. As one of the men stated,

I'm all with the bootstrap theory but sometimes somebody else got to lace it. So, we belong in this thing together. There's no separating out what's our responsibility and what's other people's responsibilities to us.

Social Networks and Social Capital

There were two themes related to men's social networks and social capital:

- The church represents a significant social network, with the potential to influence the health of African American men; however, church pastors also contend with competing responsibilities, making them less involved in their communities.
- Mentoring other men in the community, especially across generations, is an opportunity for African American men to exchange wisdom and resources, serve as mentors and role models, and nurture social action.

Photo discussions revealed themes related to how responsibility for promoting change in communities might be accomplished not only through the efforts of individual community residents but also through reciprocal social action. As such, the concept of social capital or

resources that benefit individuals through positive social relationships based on mutual trust and a sense of reciprocal obligation represent a means of mobilizing responsibility at the population level. African American men identified a number of such resources during the discussions.

A prominent institution within the community, acknowledged across all photo discussions with the men, was the church. One particular photo prompted a long discussion among urban African American men (see Figure 3):

This one is a picture of a church. I see this as the foundation of the African American community ... and I think it would be the major source of dissemination of information in an effective way.

Men described the church as a place that provided benefits through nurturing a sense of belonging in the community. Moreover, the church was recognized as a community resource that provided strength and support during times of need. Churches also afforded African American men with an opportunity to connect with other men. In this way, the church represented a significant social network to the men, with the potential to positively influence the health of other African American men in the community.

The discussions also revealed, however, how the church's potential was not being fully realized to the benefit of the community as a whole. African American men in the rural county, in particular, discussed how the significance of the church had waned over the years. Similar to the reality of competing with multiple demands that the men cited as a barrier to their more fully engaging in healthy activities, rural African American men noted that church pastors also struggled with contending priorities. For example, some pastors only worked part time and did not live in the communities where they pastored. These competing responsibilities resulted in pastors being less involved in their communities.

Despite these competing priorities, African American men in the photo discussions acknowledged how the commitment to positive change in their communities might best be organized from within the community. In other words, men felt that such a commitment to community solutions needs to begin with a collective consciousness of "being accountable to ourselves." And, among men in the photo discussions, the necessity to mentor other men in the community was cited as an opportunity for change:

Not taking nothing back from the women that are doing an outstanding job, but if they could let a Black man to show the way and the knowledge to another Black man. And, I think that's the biggest problem in our communities now, that you don't have enough Black men going back to these communities. You know, taking these men under their wing and saying, "Brother, I'm going to show you the ways and the knowledge."

Men also suggested that mentorship of wisdom and resources be shared across multiple generations of community members. Urban African American men, in particular, discussed the importance of mentoring younger African American men:

I think most men now our age, when it comes to mentoring, are trying to focus on the younger generation because if we don't they're going to be lost ... and these young minds are fresh. They're more impressionable and it's probably easier to mold those guys into responsible young men in the future. I mean there's a lot of guys, like you said, you can help them 'til the cows come home and that's all they want you to do is help them. They don't want to do anything themselves. And so I think we tend to focus on the younger generation now.

The significance and need for mentorship of men across generations, however, is not without its challenges. With regard to young men, African American men spoke about declines in

efforts to reach out to these men, a lack of positive role models in the community, as well as having limited resources to pass along. These challenges were poignantly stated by one of the urban African American navigators:

But it comes to the fact that men don't, I guess, invest in these younger guys anymore. I know when I was coming up, you know, I had numerous male role models in my life [who would] correct me right there on the spot. Whereas these days, especially with single parent homes, they're able to get away with a lot of stuff. Because you really don't have nobody that's at home, because you have one, your one Uncle, [who] is working late shift so there's nobody there to show them the way.

Moreover, the challenge of providing mentorship across generations is not limited to younger men, but also older men in the community. In particular, urban African American men discussed their difficulty in attempting to reach men with well-established patterns of unhealthy behavior:

I think we try to, you know, where we can, to mentor the older guys 'cause there are some older people who, they need mentoring too. But I think we are more reluctant because we've been burned by these guys before, you know.

Discussion

Implications for Public Health Research and Practice

The results of this study reveal that the African American men who served as navigators with the "MAN for Health" project had a sophisticated understanding of three social determinants that influence their health and the health of their communities: societal stratification through (a) racial discrimination, (b) male gender socialization, and (c) neighborhood environment. In addition, the photovoice methodology engaged them in defining relevant constructs for future research, explaining their mechanisms and intersections, and identifying strategies for engaging African American men in individual and community action to address these social determinants. In this section, we describe the extent to which our findings are supported by the empirical and theoretical literature, suggesting that social determinants of health are the root causes of poor health outcomes among racial and ethnic minorities (Krieger, 2005; Link & Phelan, 1995).

Interpersonal racial discrimination—Regarding societal stratification through racial discrimination, the men recognized that interpersonal racism influenced their health, both as a daily stressor and in creating a sense of fear and mistrust of the health care system. This finding was consistent with Krieger's Ecosocial Model, which suggests that racial discrimination impacts health through several pathways, including socially inflicted trauma and inadequate health care (Krieger, 2000). Other qualitative studies have identified racism as a barrier to health for African American men (Griffith et al., 2007; Ravenell et al., 2006; Royster et al., 2006). In addition, it supports the findings of empirical studies demonstrating that interpersonal racial discrimination negatively influences African American men's intentions to seek preventive health services, as well as their mental and physical health status (Clark, Anderson, Clark, & Williams, 1999; Paradies, 2006; Trivedi & Ayanian, 2006; Williams, Neighbors, & Jackson, 2003).

Despite these stressors, the men in this study found unity and solidarity in their racial identity, which are important strengths that can be used for community organizing and social action. Hence, as implications for future research and practice, the findings suggest distinguishing the construct of interpersonal racism from institutional racism, their respective measurements and effects. Jones (2000) has defined different levels of racism occurring at multiple levels of society in the United States, including both interpersonal and institutionalized racism.

Interpersonal racism refers to personally mediated forms of racism, such as prejudice and discrimination. It manifests as lack of respect, suspicion, devaluation, “scapegoating,” and dehumanization of oppressed racial groups, whereas institutionalized racism occurs at the systemic level and is defined as differential access to the goods, services, and opportunities of society by racial group. It manifests in both material conditions, such as the quality of education and housing, as well as access to power, such as differential access to information, resources, and political representation.

Moreover, with regard to public health practice, study participants recommended interventions that engage African American men, one on one in a mentoring relationship, to model (a) decisions as informed consumers and (b) active coping skills with encounters of interpersonal racism in their daily lives. This is also consistent with theoretical perspectives suggesting that more active responses to discrimination can mitigate its harmful effects (Krieger, 2000; Paradies, 2006). Lay health advisor interventions for African American men, therefore, could consider emphasizing the dyadic relationship to strengthen interdependence between a man and his lay health advisor (Kelley et al., 1983; Lewis, DeVellis, & Sleath, 2002; Rusbult & Van Lange, 2003). Such an intervention would focus on increasing the frequency and diversity of interaction between men, as well as their level of closeness.

Institutional racism and social capital—According to the men in this study, institutional racism influenced their health through the mechanism of neighborhood environment. Living in racially segregated neighborhoods decreased the availability of resources to maintain their health, increased their exposure to unhealthy products, and served as a chronic stressor. According to the ecosocial model, this finding exemplifies two additional pathways through which institutional racism influences health: economic and social deprivation, and targeted marketing of unhealthy substances to racial minorities (Krieger, 2000). Studies have demonstrated that African American neighborhoods are less likely to have healthy food options, with a higher distribution of liquor stores, and that these environmental exposures are linked to poor health outcomes (LaVeist & Wallace, 2000; Lewis et al., 2005; Morland, Wing, Diez Roux, & Poole, 2002; Romley, Cohen, Ringel, & Sturm, 2007). The men also explained that unhealthy products, including fatty foods and alcohol, were disproportionately marketed to African Americans. This finding is supported by studies of outdoor advertising in African American neighborhoods and advertising during African American television programs (Alaniz, 1998; Henderson & Kelly, 2005; Kwate, Jernigan, & Lee, 2007; Kwate & Lee, 2007).

Finally, the men pointed to the conditions of their neighborhoods as an influence of institutional racism on their health. Buildings that had been abandoned or were in disrepair represented reminders of institutional racism, which served as stressors to the men. Similarly, a qualitative study of African Americans in New Orleans similarly found that the conditions in neighborhoods in the Ninth Ward reflected the government’s lack of concern for poor minority residents, which in turn impacted their decision to not evacuate before Hurricane Katrina (Elder et al., 2007).

In short, neighborhood environment and institutional racism appear to have an important association with the social capital in the lives of African American men. The concept of social capital has been defined as resources that benefit individuals through positive social relationships, based on mutual trust and a sense of reciprocal obligation (James, Schulz, & van Olphen, 2001; Sampson, Morenoff, & Earls, 1999). Hence, future research that builds on neighborhood indicators of social capital, such as abandoned buildings, needs to examine how the neighborhood environment might act as a mechanism for explaining why institutional racism is associated with health outcomes among African American men.

Moreover, such findings could move men's health programs forward by mobilizing resources and responsibility for interventions at the neighborhood or community levels. The implication for practice would be to focus on policies that (a) increase incentives for health-promoting businesses, such as grocery stores or gyms, to locate in African American neighborhoods; (b) decrease incentives for health-damaging enterprises, such as fast food businesses and alcohol outlets; (c) promote access to public facilities, such as lighted public parks and high school tracks; (d) enforce local and state housing codes to increase the availability of quality housing and reduce blight; and (e) enhance the quality of public education, expand job training, and increase access to employment opportunities providing sufficient wages and benefits. Using approaches that build on the existing social capital in African American communities (discussed in the following section) might also be effective.

Male gender socialization and social capital—Photovoice participants' descriptions of how the roles and responsibilities of being a man influenced their health are consistent with those reported by focus group interviews with African American men in both urban and rural North Carolina. In both studies, male gender socialization had important influences on health (Griffith et al., 2007; Royster et al., 2006). The dominant form of masculinity in Western society includes socialization to display strength, power, independence, and stoicism, to avoid emitting any emotion or vulnerability that could be construed as weakness, and can lead to men adopting risky and/or unhealthy behaviors (Courtenay, 2000; Hong, 2000). These attitudes and behaviors were reflected in the men's discussions about failing to prioritize their own health because of their conceptions of masculinity and their roles as family providers and community members. Others have suggested that the behaviors that occur as a result of male gender socialization are magnified for African American men, who face other societal and community-level barriers such as racism and socioeconomic inequalities (Griffith et al., 2007). This might even further decrease the likelihood that African American men will follow recommended health guidelines or seek health care, health screening, and health information (Aronson, Whitehead, & Baber, 2003).

Another aspect of African American men's gender socialization that the men identified as a health influence is the concept of responsibility. Responsibility among African American men has been defined as taking, handling, or being aware of one's responsibility to oneself, one's family, and others (Hammond & Mattis, 2005). Men in the study identified lack of responsibility among African American men as a barrier to men's health, because it prevented them from taking care of themselves and their families. However, they also saw sense of responsibility to self, family, and community as a necessary trait for improving the health of African American communities. Therefore, this aspect of African American male identity might be health protective.

African American men in this study further suggested how the socialization of men might be improved through mobilization of social capital. For example, rural African American men indicated that social action at the community level might best be promoted through social institutions, such as the church. This is consistent with scholarship regarding the church as a particular source of social support and social action for African Americans. The African American church has been identified as essential to African American community life by serving as a focal point of social involvement, emotional assurance, and political activism (Ellison, Boardman, Williams, & Jackson, 2001; Levin & Taylor, 1998; Snowden, 2001).

However, African American men in our study cited how the full potential of the church to facilitate social action has been declining because of competing demands being placed on church pastors. The concern regarding declining levels of civic engagement has been noted by both classical and contemporary theoretical proponents of social capital, including Alexis de Tocqueville (1831/1959) and Robert Putnam (1995), respectively. In particular, Putnam has

cited the declining participation of adults in not only churches, but also in parent–teacher organizations, labor unions, and volunteer associations as evidence of America’s declining social capital. Despite these concerns, the African American men in our study expressed a commitment to healthy collective action and social change that best originate from and take place within their communities. In particular, they cited the importance of men being able to mentor other men as a means of modeling individual healthy behaviors while promoting more community consciousness regarding community health and well-being.

Strengths and Limitations of the Study

A strength of this study was its analysis of data collected through the CBPR approach, which engaged African American men as coinvestigators. The CBPR methodology of photovoice enhanced the quality and validity of research by drawing on rural and urban African American men’s expertise to generate an understanding of issues that they, themselves, deem important, as well as to move toward identifying action steps (Lopez et al., 2005).

At the same time, this study has three limitations. The photovoice methodology was conducted as part of the process evaluation for the larger “MAN for Health” intervention study. The photo assignments were not meant to expressly answer research questions about social determinants of health. The men might have responded differently, therefore, had they been asked to document social determinants explicitly. However, the discussion of these topics did arise naturally as part of the larger discussion of their role as lay health advisors in their communities. A second limitation is that the experiences and insights expressed during the photo discussions were those of middle-aged African American men, with a mean age of 45 years. It is therefore likely that the views of younger men would have added breadth to the findings. Because of the limited sample, these findings are not necessarily transferable to other African American men.

A third limitation is related to the lay health advisor position of participants in this study. Recruited to serve as navigators for the “MAN for Health” project, their views do not reflect those of low-income African American men at high risk for illness and disease. Rather, their views reflect those of African American men with more stability in their lives than those who turn to them for support and assistance. Consequently, this study’s sample of lay health advisors were well educated, engaged in full-time work through one or more jobs, and reported moderate to high family income levels. Although they acknowledged the unique challenges of engaging men who are struggling with inadequate education, unemployment, and poverty, this group of lay health advisors also recounted personal struggles in overcoming these barriers. Hence, they provided a unique “wide angle” lens for viewing the daily lives of lay health advisors as well as those of the African American men they are reaching.

Conclusion

In summary, African American men who served as lay health advisors delineated specific social determinants of African American men’s health: interpersonal and institutional forms of racism, male gender socialization, and social capital. Their sophisticated understanding of the intersection among these three social determinants is derived from the reality of their lived experiences. This study is one of the first to engage African American men in constructing the relevance and meaning of social determinants to their health and well-being through a systematic methodology of taking photographs and then discussing them to move toward social action.

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Figure 1. St. Agnes Hospital

Note: This photo, taken by a photovoice participant, shows St. Agnes Hospital, which once served as the only hospital serving African Americans in the area.



Figure 2.
The Liquor Section in a Grocery Store



Figure 3.
Photo of a Local Church

Table 1

Photo Assignments Chosen by Participants at Each Project Site

Urban County	Rural County
Black men being reactive instead of proactive	Men we are not reaching
What it's like to be a Black man in Raleigh	Men's fears
Irresponsible Black men	Things that are unhealthy about my community
What's frustrating about being a navigator?	Things that are healthy about my community
Why is it so hard to get confidants to participate?	My role as a navigator
Black men's lack of knowledge about health	My relationship with my confidants